Joining Forces

Volume 1 Issue 4 | *RESEARCH NEWS YOU CAN USE* | July 1997

This edition of *Joining Forces* focuses on programs that support new parents. Generally, these are prevention programs designed to improve family functioning, promote child development, and influence positive parent-child interaction. Some research has demonstrated that home-based services may reduce the occurrence of child abuse and neglect.

At Army installations, the implementation and configuration of programs that support new parents differ. Their goals and strategies are often based upon nationally recognized child abuse and prevention programs such as "Healthy Families America," "Healthy Start," or some variation of these tailored to specific needs and resources.

The two Army programs that are highlighted in this edition are the New Parent Support Program (NPSP) and FIRST STEPS. Both programs include a home visitation component. The difference is that FIRST STEPS uses trained home visitors who may be paraprofessional volunteers while NPSP uses home visitors who are professionally trained social workers or nurses.

Support Programs for New Parents

In recent years, programs that support new parents have grown in number. They are designed to strengthen the bond of parent-infant relationships and intervene with parents either during pregnancy or immediately after birth.

Home visitation, employing either professional or paraprofessional visitors, is a significant component of programs that support new parents. Often, home visitation, along with various other interventions, influence parental attitudes and maternal adjustment. Olds et al. (1986) report that intense home visitation resulted in fewer reports of child abuse. Findings indicated that the children of home-visited mothers were rated as having more positive temperaments than non-home-visited mothers and caused fewer problems. In addition, there were fewer instances of conflict, less scolding, less restriction, and less punishment of children.

Research shows that the more intense the home visitation program, the more benefit families derive from it. Only minimal gains have been associated with very brief home visitation efforts. When family support services are offered, they are usually built around models of practice that focus on family interrelationships, parental well-being, parent training, and healthy child development. New parents learn about behavioral responses of their children and how they can improve their interactive skills with them. When the services are well defined and structured to meet the specific needs of families, they seem to produce positive results.

Olds, D.L., Henderson, C.R., Chamberlain, R. and Tatebaum, R. Preventing child abuse and neglect: A randomized trial of nurse home visitation. *Pediatrics* (1986) 78:65-78.

In This Issue...

Models of Home Visitation: Old Concept - New Challenges

Home visitation by nurses, social workers, and physicians is certainly not a new concept. For social workers, the process of home visiting goes back at least to the last half of the 19th century. In those days, "friendly visitors" were assigned to families for relationship building and to support the helping process.

What are the current home visitation challenges? One would be to standardize home visitation initiatives to better ensure child abuse and neglect prevention. Another challenge would be to use the process to better understand and provide services to enhance parent-infant attachments and to decrease abuse-provoking interactions. A third challenge would be to select - from the wide variety of child abuse prevention strategies currently in use - features known to enhance parenting and teach parents how to problem-solve before they engage in abusive behaviors.

Professional or para-professional home visitors help child abuse prevention programs meet their challenges. Carrilio (1997) reports that professional vs. paraprofessional models of home visitation are not absolutes in that they exist on a continuum. She explains that the titles used by home visitors define their level of education without providing information about their skills, talents, and abilities. Further she states, "It is true that professionals may do a better job, given their training and education... but para-professionals have the possibility of being good home visitors by virtue of their personal strengths and actual experience with the target population served."

What are the Pros and Cons of using either professionals or paraprofessionals to conduct home visitation programs?

Professionals

Pros

- Formally trained/educated
- Experience in relevant field
- Professional confidence - i.e. making decisions, solving problems, assessing families
- Less boundary confusion
- Skilled in performing multiple tasks
- Understand empowerment balance - ***Teamwork***
- Committed to specific career
- Comfortable identifying & exploring feelings
- Comfortable in various professional roles

Cons:

- May not have relative experience to client; unable to identify/relate
- Lack of connection to the community; unaware of local resources
- May lack life experience
- Discomfort with working conditions/home visits/ danger of the job and/or neighborhood
- Ambivalent about career objectives (social work vs. therapy)
- Professional distance

Paraprofessionals

Pros:

- Grass-roots connection; often relates well to clients; credible to families
- Knowledge of the community & its resources
- Characteristics may be similar to those who are receiving services; rich life experiences (i.e. successful parenting experience)
- Very enthusiastic/eager to learn
- Warm, genuine, easily establishes rapport

Cons:

- Lack formal training
- Minimal professional experience
- Skeptical of own assessments, observations, and instincts

Joining Forces

MWR
Serving America's Army

Editor-in-Chief
James E. McCarroll, Ph.D.

Editor
John H. Newby, D.S.W.

Copy Editor
Kari McFarlan, B.A.

Joining Forces is a publication of the Community and Family Support Center and the Family Violence and Trauma Project at the Department of Psychiatry, Uniformed Services University of the Health Sciences, Bethesda, Maryland 20814-4799.

EMAIL: KMCFARLA@USUHS.MIL

TELEPHONE: 301-295-2470

- Personalize relationships-boundary confusion
- Difficulty performing multiple tasks/problem-solving
- Struggle with issues of power and authority
- Ambivalent about personal/professional goals
- Overwhelmed by complex situations/families
- Commonly feel helpless and powerless in organization

What kind of training should professional and paraprofessional home visitors have?

1. Professional development should be continual, frequent and ongoing.
2. Differences among individuals (Paraprofessionals and Professionals) should be considered.
3. Trainees should be involved in on-going training.
4. Training should be program-specific and content-specific.
5. Speakers from the community/seminars/workshops should be used.
6. Training should be accomplished through different modalities for optimal learning and professional development.
7. Individual, group and experiential (on-the-job) training methods should be used.
8. The training should include discussions about risk assessment, problem-solving, establishing and maintaining boundaries, setting limits with clients, self-awareness, personal safety, local police department collaboration, child development, mandated reporting, indicators of child abuse/neglect, domestic violence, etc.

Carrilio, T. Using professionals and paraprofessionals effectively: A team approach. Proceedings of the Western Regional Home Visitation Conference. Sacramento, CA, 1997.

Editor's Note: We would like to thank Dr. Terry Carrillo, Center for Child Protection, Childrens Hospital, San Diego, CA, for granting us permission to extensively quote from her paper.

The Army's New Parent Support Program (NPSP)

The NPSP is a community-based prevention program that expands the existing Family Advocacy Program (FAP) prevention services, and complements existing new parent services. Service delivery is accomplished through outreach to expectant and new parents. The program is similar in scope to nationally recognized home visitor prevention programs.

A key element of the NPSP is home visitation services in which visits to new parents begin at the time of birth and continue during the critical first months and, if necessary, the first years of the child's life. Those parents appearing at greater risk for abuse receive intensive follow-up services.

The NPSP operates on the following assumptions:

1. Parents and the home are central to a child's experience and development.
2. The well-being of parents is essential to healthy family functioning.
3. Increasing parental abilities, awareness, and appropriate expectations are critical to the prevention of child abuse and neglect.

Operating with the above assumptions, the overall goals of the program are to:

1. Strengthen healthy family functioning through community-based primary prevention services.
2. Reduce the potential for family maltreatment by meeting the psychosocial needs of parents and families.
3. Reduce the negative impact of child abuse/neglect by facilitating positive family change through individualized interventions.

New Parent Support Program at Fort Lewis, Washington

Cathy Cox, NPSP Director

For the past two and a half years Ft Lewis has had a very productive New Parent Support Program (NPSP). Approximately 1,500 families have been referred to the program since it started in February 1995. This home visiting program provides supportive and educational services to help Army families enhance their parenting skills and cope with the day-to-day stresses of family life in the military. Home visits, parenting classes, and a playmorning program are available free of charge to Army families who are expecting a baby or who have at least one child in the home age six or younger.

Home visits, parenting classes and playmorning activities are the core components of NPSP. The guidance of an advisory committee and cooperation with the Family Advocacy Program

Continued on page 4...

Continued from page 3...

Manager and Social Work Service have helped ensure the most appropriate use of NPSP for local families.

Home visits are provided both to families living on post and to those living in the surrounding communities. Families receive about three home visits each month and, when possible, visits are scheduled so that both parents can participate. NPSP parenting classes specifically focus on toddler issues. Playmorning activities are loosely structured for parents and their preschool-age children to engage in socialization activities with other families.

Many of the families receiving home visits are young, newly married, new to the Army, and new to parenthood. Ft Lewis' NPSP staff has recently noticed an increase in the number of very young couples with mothers under the age of eighteen being referred for services. In these cases, the home visitor serves as a surrogate extended family to help the young parents learn to deal with all the new experiences they face. Parents who are separated from their active duty spouse, due to deployment on unaccompanied overseas tours, also benefit from the supportive interaction with a home visitor to help them learn to parent and deal with family issues by themselves.

NPSP at Ft Lewis is well established and services are often coordinated with other military and civilian agencies. The home visitor is able to provide professionals with a unique view of families from an assessment of how they function in their home over a period of time. This unique assessment has been helpful to other professional agencies when the effectiveness of services and level of the family's participation need to be evaluated. As the NPSP is expanded to more sites, it is hoped families will be able to continue receiving the services they need even when they transfer to new assignments.

Strong Families - Strong Soldiers - A FIRST STEPS Approach

Dr. Marney Thomas,
Family Life Development Center, Cornell University

The current focus of the Army's prevention effort - Strong Families, Strong Soldiers - is to assist the Family Advocacy Program Managers in implementing and evaluating prevention programs designed to prevent spouse and child abuse as designated under AR 608-18.

Lessons learned from previous research on both experimental and quasi-experimental studies (Olds and Kitzman 1986, 1993; Larner 1980, 1992; Weiss 1987; Wasik et al. 1990) reflect both optimism and caution in evaluating the preventive effects of neonatal support programs which include home visitation. No single program or event protects children, optimizes parenting and prevents child abuse. The literature suggests that effective programs operate over time (6 months to 3 years) and provide a blend of services: health and parenting education, emotional support to mother/family, instrumental support to mother/family, service linkages, broadening of the family's social network, assistance with family planning, educational achievement, and work force participation.

Findings from these studies suggest a variety of possible outcomes:

- prevention of poor birth outcomes
- benefits in cognitive and motor development for medically "at-risk" children
- increased utilization of preventative health services
- decreased use of emergency room services for accidents, abuse, and neglect conditions.

Most evaluations have concluded that the development of a trusting relationship between the service provider and the parent is critical. Various intervention behaviors such as listening to the parent, providing information, responding to the specific concrete needs of the family, promoting effective use of support systems, and articulating alternatives have all been identified as helpful by program participants.

Conclusions derived from the research on the staffing of such programs show differing results with professionals and paraprofessionals. Correlational studies of intensity, duration and timing of onset of services suggest weekly rather than monthly contacts appear more beneficial. There are obviously many questions still to be answered. None of the studies as yet have confirmed overall lower rates of child abuse (although several additional randomized trials are underway and several unpublished reports have suggested a lowered rate of child abuse.)

FIRST STEPS began in Georgia in 1984 and currently operates in 47 civilian sites in Georgia with 46 programs in 15 other states, 5 in Europe and 14 programs on different military installations in the U.S. and overseas.

The FIRST STEPS program utilizes trained volunteers to offer services to expectant and new parents in hospital/prenatal clinic settings as a primary child abuse prevention program. The program is offered to all expectant and new parents and is entirely voluntary.

Volunteers offer families:

- emotional support
- opportunities to share experiences
- reinforcement of positive parenting skills
- contacts through phone calls, mailing, and/or home visitation for at least three to six months after the delivery of the baby
- encouragement to call the volunteer or use a 24 hour help line number at anytime
- a link between family and community resources
- educational information on child development, infant health and safety, infant stimulation, parenting, and community services.

Additionally, FIRST STEPS provides technical assistance, training and consultation for new and on-going programs and has recently instituted a formal evaluation protocol to determine if it reduces the incidence of FAP cases.

Larner, M. Realistic expectations: Review of evaluation findings. In *Fair Start for children: lessons learned from seven demonstration projects.* M. Larner, R. Halpern, and O. Harkavy, eds. New Haven, CT: Yale University Press, 1992.

Olds, D.L., Henderson, C.R., Chamberlain, R. And Tatebaum, R. Preventing child abuse and neglect: A randomized trial of nurse home visitation. *Pediatrics* (1986) 78:65-78.

Olds, D.L. and Kitzman, H. Review of research on home visiting for pregnant women and parents of young children. In *The Future of Children: Home Visiting.* David and Lucille Packard Foundation, 1993.

Wasik, B.H., Bryant, D.M. and Lyons, C.M. Home visiting: Procedures for helping families. Newbury Park, CA: Sage, 1990.

Wasik, B.H., Ramey, C.T., Bryant, D.M. and Sparling, J.J. A longitudinal study of two early intervention strategies: Project CARE. Child Development (1990) 61:1682-96.

Weiss, H. Home Visits: Necessary but Not Sufficient. In *The Future of Children: Home Visiting.* David and Lucille Packard Foundation, 1993.

U.S. Advisory Board on Child Abuse and Neglect. *Child abuse and neglect: Critical first steps in response to a national emergency.* No. 017-092-00104-5. Washington, D.C.; U.S. Government Printing Office, August 1990.

FIRST STEPS at Fort Benning, Georgia

Rebecca Welch,
Family Advocacy
Program Manager
Vivian Hanson,
FIRST STEPS Coordinator

The Family Advocacy FIRST STEPS Program is a parent support program for Ft Benning families that begins at Martin Army Community Hospital. New military parents get information about being parents, hear about services in their community, are offered the services of a home visitor on a voluntary basis, and talk to the FIRST STEPS Coordinator or volunteers about their current situation, or their own childhood. The FIRST STEPS Coordinator or volunteer visits each new parent in the hospital and takes a tote bag filled with valuable information to them. The tote bag consists of a FIRST STEPS Calendar, a "Baby Go To Sleep" cassette tape, with nursery rhymes, "101 Ways to Cope with Stress," a tubby tub tester, and many other valuable items.

After leaving the hospital, the FIRST STEPS Program can continue in the home if the couple wishes. A home visitor, who is a FIRST STEPS volunteer, helps the parents meet their immediate needs, such as securing adequate and appropriate food, applying for social services programs or assisting in handling a family crisis.

The FIRST STEPS Coordinator or volunteer offers emotional support to help new parents cope with the stresses of caring for a newborn, especially stress that comes from lack of sleep or an infant's crying. FIRST STEPS volunteers help promote the attachment between parents and their new baby.

The program also teaches basic child rearing skills, such as how to make an infant feel secure; getting a baby on a regular eating and sleeping schedule; and keeping young children safe indoors and out. The program also models positive parenting and makes referrals to community health nurses.

The editors wish to thank all of the contributors to this edition of Joining Forces. "Hooaaah!"

Understanding Rates per 1,000 Using the Four-Fold Table

Let's continue the discussion on rates from the last newsletter relative to what more they can tell us besides some quantity per 1,000. Knowledge of this procedure will help answer the commander's question, "How are we doing?"

Suppose one has a population of persons in which it is known that either spouse or child abuse occurs. You can construct a table with four separate cells and four margins, called a four-fold table.

Suppose that you want to compare the rate of child abuse among right-handed persons with that of left-handed persons for one year. You find in your cases that you have 75 right-handed persons and 15 left-handed person. You also know that there are a total of 2,500 right-handed and 650 left-handed persons on post. (These numbers are fictitious and were created solely for the purpose of this exercise.) You put this information into your table (see below).

	R-handed (Index)	L-handed (Comparison)	
Cases	75	15	90 Total Cases
Non Cases	2,500	650	3,150 Total Non Cases
	2,575 R-H	665 L-H	3,240 Grand Total

The columns are labeled with an index group and a comparison group. Notice that we have added margins to the table which are the sums of the rows and columns.

You calculate the rate of substantiated cases among the right-handed persons by dividing 75 by 2,575; that of the left-handed persons by dividing 15 by 665. You will see that there is a difference. It might look small, but looks can be deceiving. The rate among right-handed people is 0.029 (or 2.9%) while the rate in the left-handed group is 0.023 (or 2.3%). In this case, you see that your hypothesis looks like it was correct, right-handed people have a higher rate of child abuse than left-handed people, but how much higher? If you divide the rate for right-handed people (0.029) by the rate for left-handed people (0.023), you will calculate the rate ratio, 1.29.

The rate ratio has other names such as relative risk and risk ratio, but we will stick with rate ratio here. You may say that the difference between these two rates does not amount to much, but actually the interpretation is that the right-handed people have about a 30% elevated risk of being child abusers than the left-handed people. This is obtained by taking the value of 1.29 and subtracting 1 from it. The magnitude of the rate ratio for the period of time in question is calculated as the rate ratio minus 1, i.e., 1.29 - 1.00 = 0.29 or 29%. The statistical significance (whether the resulting rate ratio is likely to be due to chance) of this difference in rates can also be calculated.

Another statistic which is commonly reported in the literature is the odds ratio which is calculated by multiplying the cells in the table that are on the diagonals. For example, if you multiply 75 time 650 and divide that quantity by 15 times 2,500, you will get 1.3, about the same number as you got when you calculated the rate ratio. The odds ratio is a reasonable estimate of the rate ratio when the incidence of the events in question is low (less than 20%) and the prevalence of exposure is steady during the exposure period (Greenland & Thomas, 1982). Both of these are always considered as estimates of the "true" effect which is rarely known. (The topic of the four-fold table will be considered more fully in a later edition of this newsletter.)

The four-fold table can also be used in epidemiological research. In research where the investigator is interested in the effect of some exposure on the population, the headings for the columns of the four-fold table would be labeled "Exposed" and "Non-Exposed." They can be called anything you want as long as you note which is the index group (the group of interest) and which is the comparison group. A more complete discussion of these topics can be found in Rothman (1986).

Greenland, S. and Thomas, D.C. On the need for the rare disease assumption in case-control studies. American Journal of Epidemiology 1982; 116:547-553.

Rothman, K.J. Modern Epidemiology. 1986. Boston: Little, Brown and Company.

This newsletter was prepared for the U.S. Army Community and Family Support Center, Family Advocacy Program under an Inter-Service Support Agreement between the Department of the Army, and the Department of Defense, Uniformed Services University of the Health Sciences, Department of Psychiatry.